STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2026
NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E. Manning Avenue Fresno, CA 93725	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents environment remained free from accidents and hazards by not identifying, repairing, or replacing unsecured, lifted, or damaged floor vents in multiple resident rooms in accordance with the facility policy Safety and Supervision of Residents and Quality of Life- Home like environment for one of three sampled residents (Res 1).This failure resulted in Res 1 experiencing a fall and sustaining facial injuries, and placed other residents and staff at risk of injury due to the hazardous floor vents in 7 of 12 rooms that were observed.During a review of Res 1's History and Physical (H&P), dated 10/28/25, the H&P indicated Res 1 was a [AGE] year-old male with complex medical problems with multiple comorbidities (presence of two or more long term medical conditions leading to reduced quality of life). Res 1 was admitted for short term (around the clock care and therapeutic services to help a patient recover from an illness, surgery, or even an accident with a ultimate goal to help the patient achieve independence and a better quality of life) and long term rehab (ongoing around the clock support to assist with daily living, nursing care and medical management often longer than 90 days) from the acute care hospital following a large Middle Cerebral Artery (MCA) stroke (disruption of blood flow to the brain's largest vessel, often causing severe symptoms like contralateral paralysis (loss of voluntary movement on one side of the body caused by damage to the opposite side of the brain), facial drooping (sudden or gradual weakness of facial muscles, typically affecting one side) and speech deficits (a condition hindering clear communication, impacting how sounds are produced, words are formed, or fluency is maintained). During a concurrent interview and observation on 3/27/26 at 11 a.m. outside Res 1's room, Res 1 was observed standing outside the room with a bruise under the left eye and an abrasion on the left cheek. Res 1 stated he had fallen in his room and experienced pain. Res 1 stated he got up to use the bathroom, and his socks became caught on the floor vent, causing him to fall forward and hit his face. Res 1 stated blood came from his nose, the area under his eye became bruised, and he felt afraid for his safety and eye. Res 1 stated the floor vent had been lifted prior to his fall and that he had notified maintenance personnel in the past, but no action was taken. Res 1 stated after the fall, [MS] entered the room and repaired the vent. Res 1 stated facility staff did not appear to care about his concerns for his safety when the floor vent lifted up. Res 1 stated facility staff did offer help after the fall, but he refused to go to the hospital. Res 1 stated other rooms at the facility also had vents that were broken and lifted up and could lead to injuries to other residents.During a concurrent interview and record review on 3/27/26 at 12:05 p.m. with the Director of Staff Development (DSD), Res 1's electronic medical record (EMR), undated was reviewed. The DSD stated the nursing note on 3/26/26 at 7:01 a.m. indicated, . Around [1:10 a.m.] writer was entering in room to assess resident [room and bed number] to change resident G-TUBE [plastic tube delivers nutrition, fluids, and medications directly into the stomach] feeding. noted resident was going to use the restroom, as usually he does, noted resident falling and by the time this nurse went to resident, resident was already on the floor laying on face down. Assessed the resident and noted light nose bleed, 0.5 [centimeters (cm-unit of measurement)]x0.5 cm abrasion and bruise (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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Manning Gardens Care Center, Inc	2113 E. Manning Avenue Fresno, CA 93725

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted under left eye on the cheek. Writer immediately tum resident face on the side, cleaned abrasion . Resident denied any pain. Asked the resident what was resident doing at the time of fall, resident stated . was trying to go to the bathroom, my sock got stuck in the vent on the floor. This writer notified the maintenance to check the vent; slip was made and placed in the maintenance box . The DSD stated the nursing documentation showed staff assessed and monitored the resident and applied all appropriate interventions. The DSD stated staff notified all required parties and monitored Res 1 for 72 hours according to the facility policy. The DSD stated staff witnessed the fall and notified maintenance right away, and maintenance repaired the vent in Res 1's room. The DSD stated the Maintenance Supervisor would be the appropriate person to address details regarding the vent issue and the repair in Res 1's room.During a phone interview on 3/27/26 at 1:24 p.m. with the Maintenance Supervisor (MS) and the DSD, the MS stated he became aware of the incident in Resident 1's room and repaired the vent right away. The MS stated the corner piece of the vent had lifted and fallen inside the vent. MS stated he replaced the vent, secured it, and planned to replace and secure vents in other rooms throughout the facility. The MS stated he had been in his role since September 18th of the previous year and had observed that all vents on the floor required replacement. The MS stated Res 1 informed him that he had notified the previous maintenance staff about the vent sticking up and slipping out of place; however, the MS stated he was not aware of, nor did he have any record of previously submitted work orders. The MS stated floor vents in other rooms also had the potential to lift, move, or develop cracks, which could create safety hazards. The MS stated the facility was now replacing all floor vents that posed potential safety hazards to residents. The DSD stated that as far as she was aware, this was the first incident at the facility involving the vents on the floor leading to any safety hazards. The DSD stated as soon as she became aware of the issue, she notified the facility administrator (ADM) and the MS and directed them to evaluate Res 1's concerns and assess any other rooms that might present safety issues. The DSD stated the facility leadership had already started implementing safety precautions and actively working on ensuring resident safety by replacing vents. During a concurrent observation and interview on 3/27/26 at 2 p.m. with the DSD, all rooms were observed in the facility for floor vents and identified seven rooms (Rooms 10, 11, 12, 14, 15, 16, and 17) with floor vents that were lifted, had broken pieces, had sharp corners or edges, and/or were not secured in place. The DSD stated and agreed these vents could potentially pose safety hazards for residents in the rooms and for facility staff entering the rooms when residents were not mobile. The DSD stated to her knowledge, these vents had been in this condition for a long time and no residents or staff had expressed safety concerns. The DSD stated she was unable to explain why rooms [ROOM NUMBERS] had solid, secured vent pieces while the other rooms did not. The DSD stated the facility had already identified this gap and was in the process of correcting it. The DSD stated and agreed the vents should have been replaced or repaired earlier and that doing so might have prevented the incident with Res 1. The DSD stated to her knowledge, this was an isolated incident related to floor vents. During a phone interview on 3/30/26 at 1:29 p.m. with the ADM, the ADM stated he was at the facility on the morning of 3/27/26 prior to the surveyor's arrival. The ADM stated he had already reviewed the incident with Res 1 during the Quality Assurance (QA) meeting on 3/27/26, and the MS was instructed to replace all vents in the facility to ensure residents safety. The ADM stated the facility team had already identified this issue and had begun implementing corrective actions before the surveyor arrived. The ADM stated he had been at the facility for fifteen years and this was the first ventˆrelated incident or concern he had been made aware of. The ADM stated his team promptly worked on a solution to ensure resident safety. The ADM stated although he agreed some vents were not in great shape and required repair or replacement, no staff or residents had previously reported or witnessed safety concerns related to the vents.During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Residents, dated July 2017, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility-Oriented Approach to Safety . Our facility-oriented approach to safety addresses risks for groups of residents . Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization . Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents . The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary . The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents . The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly .During a review of the facility's P&P titled, Quality of Life-Home like environment, dated July 2017, the P&P indicated, . Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .